VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 16, 2012

Ms. Theresa Southworth, Administrator
Gill Odd Fellows Home
8 Gill Terrace
Ludlow, VT 05149

Provider #: 475052

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 14, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 3/12/12 to 3/14/12. The following deficiencies resulted from the recertification survey:	F 000	**F-250 – Provision of Medically related Social Services.** Late entry note written for resident #53 to reflect conversation with guardian during the first week of admission, of discharge planning to reflect LTC placement. Call to guardian on March 16, 2012 and discharge plan confirmed. All residents or their families contacted related to discharge and care planned appropriately. A single social worker named to ensure documentation. Care Plan meeting note worksheet has been updated to include discharge planning and will be reviewed at every care plan meeting for every person. MDS coordinator or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide medically-related Social Services to attain or maintain the highest practicable physical, mental and psychosocial well being of 1 of 2 Residents (Resident #53) identified in the Stage 2 sample. The findings include: 1. Per record review on 3/14/12, Resident #53 was admitted on 10/13/2011 with numerous diagnosis including failure to thrive and a bone fracture related to a fall. Per review of the Social Services initial assessment, Resident #53 was admitted for short term rehabilitation and was to return home with anticipated length of stay to be 1-2 months. Per review of the physical therapy notes dated 12/2/11, Resident #53 was discharged from physical therapy services related to meeting all physical therapy goals. Review of the nurses notes showed no evidence of what	F 250		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth — TITLE: Administrator — (X6) DATE: 4-10-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

pmc

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F 250	Continued From page 1 Resident #53's disposition was to be. Per review of Resident #53's care plan meeting notes, there is no evidence that disposition was discussed during the meetings. Review of the comprehensive assessment dated 10/20/11, 10/30/11 and 1/12/12, the assessment was coded that Resident #53's discharge plan was that "return to the community was not feasible". Per review of Resident #53's comprehensive care plan, there was no evidence of any discharge planning. Per interview with the facility Administrator and Director of Nursing Services (DNS) on 3/14/12 at 10:34 AM, it was confirmed that there was no evidence within the medical record of that Resident #53's discharge disposition had been discussed with the interdisciplinary team and Resident #53's family and there was no evidence to explain why Resident #53's discharge disposition had changed from return to home to return to the community not feasible.	F 250	F250 POC accepted 4/12/12 TDougherty RN/DNcotaRN	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide or arrange for services by a qualified person in accordance with the plan of care for 5 residents (Residents #53, 20, 5, 2 and 11) identified in the Stage 2 sample. The findings	F 282	**F-282 – SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Resident # 53 screened by Occupational therapy. Residents #20, # 5, # 2 and # 11 have call bell hooked to bed and a hand bell attached to wheelchair.	

Theresa Southworth Administrator 4-10-12

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F 282	Continued From page 2 include: 1. Per record review on 3/14/12, Resident #53 was admitted on 10/13/2011 with numerous diagnosis including failure to thrive and a bone fracture related to a fall. Resident #53 was admitted for short term rehabilitation and was to return home with anticipated length of stay to be 1-2 months. Per review of the Occupational therapy documentation, Resident #53 was evaluated on 10/18/11 and was to receive Occupational Therapy for a diagnosis of general weakness and malaise. The documentation indicated that Resident #53 was to receive treatment 5 days a week for 5 weeks for ADL (activities of daily living) training, therapeutic exercise, therapeutic activities and neurological re-education. The documentation indicated that Resident #53's specific goals were for grooming, functional mobility, dressing, bathing and toileting. Per review of the physician's orders dated 11/23/11 "discontinue skilled occupational therapy secondary to staffing issues." Per review of the Occupational Therapy weekly summary dated 11/23/11 the plan was documented to "discontinue occupational therapy secondary to staffing issues." Per review of the Occupational Therapy Discharge Summary, Resident #53 was discharged from services on 11/23/11, and the documentation indicated that Resident #53 had not met two of the four goals, the goal of dressing/bathing and toileting. Per review of the medical record there was no evidence that Occupational Therapy Services were reinitiated for Resident #53 after 11/23/11. Per interview with the Director of Therapy Services on 3/14/12 at 10:13 AM, he/she confirmed that a resident	F 282	All residents screened by rehab director or designee for potential rehab services and ability to use call bell. Staff educated related to call bell policy. At minimum daily rounds to ensure call bell in reach to all residents. DNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012. F282 POC accepted 4/12/12 T Dougherty RN / P McotaRN	

Theresa Southwood Administrator 4-10-12

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F 282	Continued From page 3 can only be discharged from therapy services if they have met all there goals or if they have reached their maximum potential. The Director confirmed that discontinuing therapy services related to staffing issues is not appropriate. The Director confirmed that Resident #53 had not received any Occupational Therapy services after services were discontinued secondary to staffing issues on 11/23/11. The Director confirmed that the Occupational Therapy discharge summary indicated that Resident #53 had not met 2 of 4 goals and that the summary did not indicate whether Resident #53 had reached maximum potential for these goals. 2. Per observation on 3/12/12 at 2:28 PM, Resident #20 was in bed with the call bell located above the bed approximately 3 feet out of the reach of Resident #20. Per observation on 3/13/12 at 1:15 PM, Resident #20 was in bed with the call bell located above the bed approximately 3 feet, out of the reach of Resident #20. Per record review, there was no evidence noted that Resident #20 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #20's care plan titled, "At risk for injury related to falls" dated 2/20/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #20 is dependant on staff for activities of daily living, weakness and recent falls. Per interview with the Director of Nursing (DNS) on 3/13/12 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. The DNS visually and verbally confirmed that the call bell for Resident #20 was	F 282		

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F 282	Continued From page 4 located above the bed approximately 3 feet, out of the reach of Resident #20. 3. Per observation on 3/12/12 at 2:47 PM, Resident #5 was in his/her room sitting in a wheelchair at the left side of the foot of his/her bed. It was observed that Resident #5's call bell was on the overbed table at the foot of the bed approximately 2 feet away from the resident's reach. Per record review, there was no evidence noted that Resident #5 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #5's care plan titled, "At risk for injury related to falls" dated 3/4/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #5 has impaired balance and gait and is visually impaired. Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. 4. Per observation on 3/12/12 at 2:47 PM, Resident #2 was in his/her room sitting in his/her wheelchair on the left side of the bed. The call bell was observed to be on the right side of Resident #2's bed attached to the side rail, approximately 2 feet from Resident #2's reach. Per record review, there was no evidence noted that Resident #5 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #5's care plan titled, "At risk for injury related to falls" dated 3/4/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #2 had decreased balance, muscle wasting, and was chair bound. Per interview with the Director of	F 282		

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F 282	Continued From page 5 Nursing (DNS) on 3/13/12 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. 5. Per observation on 3/13/12 at 2:05 PM, Resident #11 was in bed in his/her room and the call bell was observed to be above Resident #11's bed attached to the wall approximately 2 feet away from Resident #11's reach. Per record review, there was no evidence noted that Resident #11 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #11's care plan titled, "At risk for injury related to falls" dated 2/12/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #11 had history of falls. Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. The DNS visually and verbally confirmed that the call bell for Resident #11 was above Resident #11's bed attached to the wall approximately 2 feet away from Resident #11's reach.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 311	**F-311 – TREATMENT/ SERVICES TO IMPROVE/ MAINTAIN ADLS** Resident #53 has been screened by Occupational Therapy and picked up for services. All residents screened by rehab director or designee for potential rehab services. All residents will have a rehab screen at least quarterly triggered by the MDS scheduling process. Rehab Director or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012.	

Theresa Southworth Administrator 4-10-12

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F 311	Continued From page 6 facility failed to provide appropriate treatment and services to maintain or improve the highest practicable well being of 1 resident (Resident #53) identified in the survey sample. The findings include: 1. Per record review on 3/14/12, Resident #53 was admitted on 10/13/2011 with numerous diagnosis including failure to thrive and a bone fracture related to a fall. Resident #53 was admitted for short term rehabilitation and was to return home with anticipated length of stay to be 1-2 months. Per review of the Occupational therapy documentation, Resident #53 was evaluated on 10/18/11 and was to receive Occupational Therapy for a diagnosis of general weakness and malaise. The documentation indicated that Resident #53 was to receive treatment 5 days a week for 5 weeks for ADL (activities of daily living) training, therapeutic exercise, therapeutic activities and neurological re-education. The documentation indicated that Resident #53's specific goals were for grooming, functional mobility, dressing and bathing and toileting. Per review of the physician's orders dated 11/23/11 "discontinue skilled occupational therapy secondary to staffing issues." Per review of the Occupational Therapy weekly summary dated 11/23/11 the plan was documented to "discontinue occupational therapy secondary to staffing issues." Per review of the Occupational Therapy Discharge Summary, Resident #53 was discharged from services on 11/23/11, and the documentation indicated that Resident #53 had not met two of the four goals, the goal of dressing/bathing and toileting. Per review of the	F 311	F311 POC accepted 4/12/12 TDoughertyRN/ dMcotaRN	

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F 311	Continued From page 7 medical record there was no evidence that Occupational Therapy Services were re-initiated for Resident #53 after 11/23/11. Per interview with the Director of Therapy Services on 3/14/12 at 10:13 AM, he/she confirmed that a resident can only be discharged from therapy services if they have met all there goals or if they have reached their maximum potential. The Director confirmed that discontinuing therapy services related to staffing issues is not appropriate. The Director confirmed that Resident #53 had not received any Occupational Therapy services after services were discontinued secondary to staffing issues on 11/23/11. The Director confirmed that the Occupational Therapy discharge summary indicated that Resident #53 had not met 2 of 4 goals and that the summary did not indicate whether Resident #53 had reached maximum potential for these goals.	F 311		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 5 of 32 residents (Residents #20, 5, 2, 11 and 7)	F 323	**F-323 – FREE OF ACCIDENTS HAZZARDS/ SUPERVISION/ DEVICES** Residents #20, # 5, # 2 and # 11 have call bell hooked to bed and a hand bell attached to wheelchair. Resident #7 and #2 have wheelchair rests on wheelchair.	

Theresa Southworth Administrator 4-10-12

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F 323	Continued From page 8 identified during Stage 1 and Stage 2 of the recertification survey. The findings include: 1. Per observation on 3/12/12 at 2:28 PM, Resident #20 was in bed with the call bell located above the bed approximately 3 feet out of the reach of Resident #20. Per observation on 3/13/12 at 1:15 PM, Resident #20 was in bed with the call bell located above the bed approximately 3 feet , out of the reach of Resident #20. Per record review, there was no evidence noted that Resident #20 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #20's care plan titled, "At risk for injury related to falls" dated 2/20/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident # 20 is dependant on staff for activities of daily living, weakness and recent falls Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. The DNS visually and verbally confirmed that the call bell for Resident #20 was located above the bed approximately 3 feet, out of the reach of Resident #20. 2. Per observation on 3/12 at 2:47 PM Resident #5 was in his/her room sitting in a wheelchair at the left side of the foot of his/her bed. It was observed that Resident #5's call bell was on the over-bed table at the foot of the bed approximately 2 feet away from the resident's reach. Per record review, there was no evidence noted that Resident #5 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #5's care plan	F 323	All residents screened by Rehab Director or designee for the ability to use call bell and for use of foot rests on wheel chairs. Wheelchairs have been marked with the matching footrests. Staff has been educated about call bells and safe transportation of residents. Rehab screen forms are available on each nursing unit and staff has been educated about requesting a rehab screen. Care plans have been updated to reflect use of foot rests with transportation of residents. At minimum daily rounds to ensure call bells in reach and appropriate use of wheelchair footrests during transportation. Nurses and LNA's will be utilized in peer assessment of call bells and wheelchair footrest audits to enhance awareness and compliance. DNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012.	

Theresa Southworth Administrator 4-10-12

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F 323	Continued From page 9 titled, "At risk for injury related to falls" dated 3/4/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #5 has impaired balance and gait and is visually impaired. Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. 3. Per observation on 3/12/12 at 2:47 PM, Resident #2 was in his/her room sitting in his/her wheelchair on the left side of the bed. The call bell was observed to be on the right side of Resident #2's bed attached to the side rail, approximately 2 feet from Resident #2's reach. Per record review, there was no evidence noted that Resident #2 had any physical limitations preventing him/her from utilizing a call bell. Per review of the Resident #2's care plan titled, "At risk for injury related to falls" dated 3/4/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #2 had decreased balance, muscle wasting, and was chair bound. Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. 4. Per observation on 3/13/12 at 2:05 PM, Resident #11 was in bed in his/her room and the call bell was observed to be above Resident #11's bed attached to the wall approximately 2 feet away from Resident #11's reach. Per record review, there was no evidence noted that Resident #11 had any physical limitations preventing him/her from utilizing a call bell. Per	F 323	F323 POC accepted 4/12/12 TDougherty RN | RMcotaRN	

Theresa ~~Southworth~~ Administrator 4-10-12

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F 323	Continued From page 10 review of the Resident #11's care plan titled, "At risk for injury related to falls" dated 2/12/12, the call bell is to be in reach while resident is in the room. The care plan also indicated that Resident #11 had history of falls. Per interview with the Director of Nursing (DNS) on 3/13 at 2:20 PM, he/she indicated that his/her expectation of staff was that all call bells are to be within the residents reach when the resident is in their room. The DNS visually and verbally confirmed that the call bell for Resident #11 was above Resident #11's bed attached to the wall approximately 2 feet away from Resident #11's reach. 5. Per observation on 3/12/12 at 12:45 PM, Resident # 7 was being transported by staff from the dining room to the unit via wheel chair. It was observed that Resident #7's feet were dragging on the ground as the staff member pushed the wheelchair forward. It was also observed that Resident #7 had no foot rests attached to the wheelchair. On 3/13/12 at 9:15 AM and 9:40 AM, Resident #7 was being transported in his/her wheelchair down the unit hallway and his/her feet were dragging on the ground as the wheelchair was being pushed forward. It was also observed that Resident #7 had no foot rests attached to the wheelchair. It was observed when staff instructed Resident #7 to lift his/her feet the resident was not able to and actually pushed his/her feet harder onto the floor. Per observation on 3/14/12 at 8:27 AM, Resident # 7 was being transported via wheelchair to the dining room. It was observed that Resident #7 had no foot rests attached to the wheelchair. It was observed when staff instructed to lift his/her	F 323		

Theresa Southworth Administrator 4-10-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 feet the resident was not able to and actually pushed his/her feet harder onto the floor. Per interview with the DNS on 3/14/12 at 8:42 AM he/she confirmed that he/she had visualized the transport of Resident #7 by staff and had observed that Resident #7's feet were dragging on the floor as the staff member pushed the wheelchair forward. The DNS also confirmed that there were no leg rests on the wheelchair and that transporting a resident whose feet are dragging on the floor was a potential for injury to the residents feet. Per review of Resident #7's Physical Therapy Assessments, there was no evidence that Resident #7 was evaluated for the utilization of a wheelchair for transport or evaluated for the utilization of foot rests for safety during transport. Per interview on 3/1412 at 8:42 AM with the Physical Therapist (PT), he/she indicated that Resident #7 was not formally evaluated for the utilization of a wheel chair for transport and was not made aware that Resident #7 was dragging his/her feet during transport. The PT confirmed that Resident #7's legs do not bend and could become injured during transport. 6. Per observation on 3/13/12 at 4:30 PM, Resident #2 was being transported via wheelchair to the dining room. It was observed that Resident #2's feet were dragging on the floor as the staff member pushed the resident forward in the wheel chair. It was also observed that there were no leg rests on the wheelchair during transport. It was observed that staff instructed Resident #2 to "lift" his/her feet during the transport and Resident #2 was unable to comply with these instructions. Per review of Resident #2's Physical Therapy	F 323		

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GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

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F 323	Continued From page 12 Assessments, there was no evidence that Resident #2 was evaluated for the utilization of a wheelchair for transport or evaluated for the utilization of foot rests for safety during transport. Per interview on 3/14/12 at 8:42 AM with the Physical Therapist (PT), he/she indicated that Resident #2 was not formally evaluated for the utilization of a wheel chair for transport and was not made aware that Resident #2 was dragging his/her feet during transport.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare and serve food under sanitary conditions. The findings include: 1. Per observation on 3/12/12 during the kitchen tour at 10:26 AM, the microwave utilized to heat resident food had dried food particles on the inside roof of the microwave oven. Per interview with the Dietary Manager (DM) the microwave is cleaned at the end of each day. The DM confirmed that the microwave had not been used yet on 3/12/12 and the microwave had not been	F 371	**F=371 – FOOD PROCURE, STORE/ PREPARE/ SERVE/ SANITARY** Microwave was cleaned and is checked daily at the beginning of each cooks shift. All unlabeled food products were discarded. Dietary Manager and Dietary Staff in-serviced related to food safety. The intake vent was cleaned 3/13/2012 by Maintenance Director. Maintenance/dietary staff was educated on Infection Control Prevention related to food storage and monthly cleaning schedule. DM to review and ensure daily, weekly and monthly cleaning schedule followed.	

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F 371	Continued From page 13 cleaned after it was used last. 2. Per observation on 3/12/12 at 10:35 AM, in the drink cooler there were two 8 ounce glasses containing cranberry juice and milk. The glasses were covered with lids but the lids were not labeled with the date the drinks were placed into the cooler. In the main cooler it was observed at 10:39 AM that there were 6 gallon containers (1/2 gallon mustard, 1/2 gallon of ranch dressing, 3/4 gallon of dill pickles, 3/4 gallon of mayonnaise, and a 3/4 gallon container of green olives), not dated for when they were open. Per interview with the DM at 10:40 AM he/she confirmed that the expectation is that staff label items when they are opened and placed in the cooler. The DM also confirmed that the facility had no policy regarding the labeling and storage of food products in the coolers and that without the dates, the staff would not be able to identify when the food items would no longer be safe to consume. 3. Per observation on 3/12/12 at 10:40 AM in the kitchen, it was observed that the intake vent located directly over the steam table and food preparation area was covered with thick black, greasy appearing dust particles. Per interview with the DM, he/she indicated that the vents were maintained by the maintenance department. Per interview with the maintenance helper on 3/12/12 at 10:45 AM, he/she confirmed that the vent was coated with thick black, greasy dust particles. Per interview with the Maintenance Director (MD) on 3/12/12 at 10:45 AM, he/she indicated that the vents are to be cleaned on a monthly basis. Per review of the preventative maintenance documentation the last time the vent was cleaned was 2/10/12. The MD indicated in interview that	F 371	Popcorn popper has been cleaned and returned to service after obtaining food safe chemical for cleaning per manufacturers guidelines. The activity staff has been educated on infection control and cleaning procedure. LNA counseled related to hand washing and Infection Prevention in the dining room. Dining practices will be monitored for infection control a minimum of 7 meals per week for food safety. Dietary Manager or designee will monitor equipment in kitchen daily for cleanliness of vent and notify maintenance if cleaning needed before scheduled cleaning date. Dietary manager or designee will monitor microwave for cleanliness twice daily. Refrigerators will be checked daily by dietary staff for labels on all food with an open date. All staff educated about infection control, Blood borne pathogens (BBP) and the importance of hand washing/sanitizing and dietary staff r/t food safety.	

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F 371	Continued From page 14 the facility did not have a policy or procedure for the cleaning of the vent system in the facility. 4. Per observation on 3/12/12 at 10:47 AM, in the main dining room it was observed that the free standing popcorn popper contained popcorn particles in the main chamber and that the inside of the glass windows were coated with a thick greasy film. Per interview with the DM, he/she indicated that the activities department was responsible for maintaining the popcorn popper. Per interview on 3/12/12 at 10:47 AM with the temporary dietary/activity aide, he/she indicated that the popcorn popper was used for facility movie nights usually every two weeks. The aide indicated that the last movie night was approximately a week ago and he/she confirmed that the popcorn popper had not been cleaned since its last use. 5. On 3/12/12 at 12:07 PM during the lunch meal observation in the main dining room it was observed that a Licensed Nursing Assistant (LNA) was feeding a resident. The aide was observed wiping his/her nose with his/her bare hand and then did not sanitize or wash his/her hands before picking up the residents sandwich with the same hand and feeding the sandwich to the resident. Per interview the LNA he/she confirmed that he/she should have washed or sanitized his/her hands before feeding the resident after touching his/her nose.	F 371	Dietary Manager or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012. F371 POC accepted 4/12/12 TDougherty RN/CMcotaRN	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

Theresa Southworth Administrator 4-10-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 15 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview on 3/12/12, the facility failed to provide a safe and	F 441	**F-441 – INFECTION CONTROL, PREVENT SPREAD, LINENS** The Medication Nurse has been counseled on blood-borne pathogens and infection control practices. The LNA has been counseled regarding hand washing and infection prevention. Dining practices will be monitored for a minimum of seven meals per week for Infection control. Staff educated on preventing spread of Infection related to dining and blood borne pathogens. Hand sanitizers available on all tables in the dining room. Nurses, LNA's and Dietary staff participate in the monitoring of Infection control in the dining room to enhance peer awareness. Director of Nursing Services or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012.	

Theresa Southworth Administrator 4-10-12

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F 441	Continued From page 16 sanitary environment to help prevent the development and transmission of disease and infection. The findings include: 1. Per observation on 3/12/12 at 12:16 PM in the main dining room during the lunch service, the medication nurse was observed obtaining a fingerstick (obtaining a blood sample from a resident for the purpose of testing the residents blood sugar level) from a resident sitting at the dining room table while other residents were eating. Per interview with the medication nurse, he/she confirmed that the resident should have been removed from the dining area when performing a fingerstick. 2. On 3/12/12 at 12:07 PM during the lunch meal observation in the main dining room it was observed that a Licensed Nursing Assistant (LNA) was feeding a resident. The aide was observed wiping his/her nose with his/her bare hand and then did not sanitize or wash his/her hands before picking up the residents sandwich with the same hand and feeding the sandwich to the resident. Per interview the LNA he/she confirmed that he/she should have washed or sanitized his/her hands before feeding the resident after touching his/her nose.	F 441	F441 POC accepted 4/12/12 TDoughertyRN/CPMcotaRN	

Theresa Southwood Administrator 4-10-12

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #: 475052	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	**8 GILL TERRACE LUDLOW, VT**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on interview and medical record review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 residents (Residents #2 and #53) of the sample group with regard to impairment of legs. Findings include:

1. Per medical record review for Resident #2 on 03/14/2012 at 9:30 am, the coding of a '2' for leg impairment on both sides on the annual MDS dated 02/23/2012 indicates a decline from the coding on the previous 2 quarterly reviews done on 12/04/2011 and 09/11/2011. Resident #2 was coded on those 2 MDS assessments as '0' or no impairment in both legs.

Per review of the nurses' notes and physical therapy notes, there has been no decline in the functional status of this resident during these assessment periods. The fact that the resident had no change in the function of her/his legs since admission is confirmed during interview with DNS on 03/14/2012 at 3:14 PM, as well as by interview with the primary physician on 03/14/2012 at 3:00 PM. The DNS further states that this is a coding error.

2. Per record review on 3/14/12, Resident #53 was admitted on 10/13/2011 with numerous diagnoses including failure to thrive and a bone fracture related to a fall. Per review of the Social Services initial assessment dated 10/16/11, Resident #53 was admitted for short term rehabilitation and was to return home with anticipated length of stay to be 1-2 months. Review of the MDS's dated 10/20/11 and 10/30/11 record Resident #53's discharge plan coded "return to the community was not feasible". Per review of the physical

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475052	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 3/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 therapy notes dated 12/2/11, Resident #53 was discharged from physical therapy services having met all physical therapy goals. Per interview with the Director of Nursing Services on 3/14/12, he/she confirmed that the MDS dated 10/20/11 and 10/30/11 did not accurately reflect the assessment of Resident #53's "returning home" documented in the Social Service notes dated 10/16/11, and demonstrated by Resident #53 meeting all physical therapy goals.

Theresa Southworth Administrator 4-10-12